ALABAMA DEPARTMENT OF MENTAL HEALTH
DIVISION OF MENTAL RETARDATION

REGIONAL COMMUNITY SERVICES
INITIAL MORTALITY REPORT

Consumer #:_____Sex:_____ Case #:_____ Region#:_____

Fname:_____ Lname:_____ Phone:_____

Race:_____Functioning Level: Mild Moderate Severe Profound

Site Address and Admission Date:_____

Residential Opr:_____ Res Site Code:_____310:_____

Reported By:_____ Date of Death:_____ Time of Death:_____

Contact Relationship/Agency:_____ Contact Phone:_____

Received By:_____ Date Received:_____ Time Received:_____

Death Code:_____ Location of Death:_____

Prog/Loc. Opr.:_____ Loc. Site Code:_____ 310:_____

Date of Birth:_____ Age at Time of Death:_____ Down's Syndrome: Y N

Name of DMH/MR SODC Discharged from:_____

Date of Discharge from DMH/MR SODC:_____

Death Pronounced by:_____

Length of Hospitalization if Applicable:_____

Was this a CPR Emergency? Y N _____

Medical Examiner Notified? Y N _____

Medical Examiner Case? Y N _____

Autopsy Performed? Y N (If No, Explain) _____

_____

I. Cause of Death:

II. Medial Diagnoses:

III. Summary of Incident:

IV. Name of Next of Kin:_____

Guardian Y N If No, Relationship:_____

Address:_____

Phone Number:_____

Date Notified:_____ Time Notified:_____

V. Follow-Up Action:_____

_____

_____

VI. Community Services Director Notification: Date:_____ Time:_____

_____ _____
Signature of Person Completing Report Date

I. Community Services Director Notification: Date:_____ Time:_____

By Whom:_____

II. Director of MR Community Services Notification: Date_____ Time:_____

By Whom:_____

III. Associate Commissioner Notification: Date:_____ Time:_____

By Whom:_____

IV. Commissioner Notification: Date:_____ Time:_____

By Whom:_____

Note: Pages 1 and 2 are to be completed to by the provider and forwarded to RCS. RCS is to complete Sections I and II of page 3 and forward to the Division of Mental Retardation Services.